Parent Request for Administration of Medication

St. Luke Catholic Elementary School

Instructions to Physician: Please complete items 1 through 12 (and reverse page for injectable medication)

1. Name of student _____Date of Birth _____
2. Address _____
3. Physical condition for which medication is being administered _____
4. Name of prescribed medication _____
5. Dosage to be administered at school _____
6. Time of medication to be administered at school: _____
7. Method of administration: Oral _____ Inhalation _____ Injection* _____

(*Complete other side)

INJECTIONS SHALL NOT BE GIVEN BY SCHOOL PERSONNEL EXCEPT IN CASES OF EXTREME LIFE-THREATENING CONDITIONS

8. Symptoms which student has shown _____
   _____
9. Possible reactions after administration of drug that need to be reported to physician: __
   _____
10. Instructions for car of student after administration of medication. (rest, home, hospital, doctor's office, return to class, other: _____
    _____
11. Medication to be continued until _____(date)
12. It is my judgment that the above medication must be taken during school hours and may be administered by authorized (non-medical) personnel/by the student him/herself.

Physician's Signature _____Date_____

Address _____

_____Telephone _____

Parent/Guardian's Request:

I understand that the school is not legally obligated to administer medication to my child; therefore, I agree to hold the school, the Diocese of Stockton and their employees free and harmless from any claim or action which might arise out of these arrangements and to defend and indemnify the school, Diocese and employees against any claims by third parties, regardless of whether the school, Diocese or its employees are actively or passively negligent. I hereby request that school staff assist my child in taking the above prescribed medication. I will notify the school immediately if any changes in the above schedule are necessary and prescribed by the physician. THE MEDICATION WILL BE FURNISHED IN ITS PHARMACY-LABLED CONTAINER.

Parent/Guardian's signature_____Date_____

Address _____Telephone _____

Request for administration of injectable medication during school hours

Physician's instructions for the administration of injectable medication:
History of severe reactions including symptoms:_____

_____

Specific symptoms requiring use of Injection Kit _____
Directions for use of Injection Kit _____

_____

Is it all right for this student to go on class field trips?_____
If yes, what are your special instructions and concerns?_____

_____

Please note: If and when the Injection Kit is used, paramedics (911) will be called.

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Parent/Guardian's Request for the administration of non-prescription medication

I understand that the school is not legally obligated to administer medication to my child; therefore, I agree to hold the school, the Diocese of Stockton and their employees free and harmless from any claim or action which might arise out of these arrangements and to defend and indemnify the school, Diocese and employees against any claims by third parties, regardless of whether school, Diocese or its employees are actively or passively negligent. I hereby request that school staff assist my child in taking over-the-counter medication provided by me for coughs, colds, allergies, pain. I understand that the medication must be in its original and the dose may not exceed that written on the container.

Please note any age-appropriate over-the-counter medications the child should <u>not</u> take.

_____

_____

_____

Parent/Guardian's signature_____Date_____
Address _____

_____Telephone _____